

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 000 | INITIAL COMMENTS Revised report following IDR request. F225 was deleted. F279 remains unchanged. Text changes were made to F280 and F314. There were no changes made to scope and severity of any tags. An unannounced QIS annual survey was conducted at this facility from October 19, 2009 through October 27, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 41. The survey sample included forty (40) census sample residents and twelve (12) admission sample residents in Stage 1. The Stage 2 sample totaled eighteen (18) residents. | F 000 | | | |
| F 157 SS=D | 483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). | F-157 | <ol style="list-style-type: none"> 1. The physician was notified of the resident's continence status at the time of the survey. 2. Notification of the appropriate party will be documented in the medical record for accidents, injuries, and for significant changes in condition or treatment. 3. Licensed staff will be in-serviced on the regulatory requirement related to notification. 4. All documented notification will be indicated on the 24-hour report which is reviewed daily by the DON/ADON. | | 12/30/09 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kim M Carr

Administrator

12/17/09

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|--|----------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 157 | <p>Continued From page 1</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined that the facility failed to notify the physician when one (1) resident (R45) out of 18 sampled Stage 2 residents had a significant change in physical status. Findings include:</p> <p>R45 was readmitted to the facility, post hospitalization, on 6/24/09 with diagnoses that included anemia, dementia and depression. The Minimum Data Set (MDS) assessment, dated 7/1/09 indicated that R45 was continent of bowel and bladder. A quarterly MDS assessment, dated 8/29/09 indicated R45 was "occasionally incontinent-2 or more times a week but not daily." Review of the clinical record lacked evidence that R45's physician had been notified regarding the decline in bladder continence.</p> <p>During an interview with E5 (nurse) on 10/26/09 at 3:10 PM, she confirmed that R45 had "episodic" incontinence, however was not able to definitively state whether the physician had been informed of the decline. In an interview with E6</p> | F 157 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 157 | Continued From page 2 (R45's physician) on 10/27/09 at 10:30 AM, when asked if he had been informed of the resident's decline in bladder continence, he stated that he was unable to say that he recalls having been informed. | F 157 | | | |
| F 241 SS=D | The facility failed to notify R45's physician of her decline in bladder continence. 483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to ensure that three (3) residents (R9, R11 and R23) were treated in a dignified manner while being fed their evening meal. Findings include: Observation of the evening meal in the main dining room on 10/21/09 at 6:00 PM revealed three (3) CNAs (E9, E10 and E11) were feeding three (3) residents (R9, R11 and R23) at the same table. Throughout the meal there was minimal interaction between the aides and the residents. E9, E10 and E11 were observed interacting more frequently amongst themselves than with the residents they were feeding. R11 was seated sideways next to the table in a geri-chair with E9 seated behind the table on the resident's right side. R11 was heard saying, "may I please have some more?" at least three times during the meal. E9 was noted looking forward | F 241 | | | |
| | | F-241 | All health care staff will be in-serviced regarding the positive dining experience. General rules regarding interaction between resident and staff will be posted in both pantry areas in addition to the in-service. Nursing supervisor will monitor the dining experience of our residents to ensure the dining experience is one that promotes dignity and quality of life of our residents. A nurse will be designated to oversee the dining room during the meal service. This monitoring will be on going for all meals. | | 12/31/09 and ongoing |

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: FRIE11 Facility ID: DE00220 If continuation sheet Page 4 of 21

11/30/09
and
ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 274 | Continued From page 4 one person for transfer, toilet use and hygiene and was continent of bowel and bladder. The quarterly MDS assessment, dated 8/29/09 indicated R45's cognitive skills for daily decision making were "moderately impaired-decisions poor; cues/supervision required" and the resident required extensive assistance for transfer, toilet use and hygiene, and was "occasionally incontinent-bladder, 2 or more times a week but not daily..." During an interview on 10/26/09 at approximately 2 PM, E8 (MDS Coordinator) acknowledged that a significant change assessment was indicated. The facility failed to identify that a significant change assessment was indicated and instead completed the 8/29/09 quarterly MDS. | F 274 | | | |
| F 279 SS=E | 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under | F 279 | <ol style="list-style-type: none"> Care plans for all four residents have been updated Nursing will be educated on the care plan process to review and revise care plans as indicated. Nurses will review resident care plans when completing monthly summaries to determine if any changes or revisions are required. The 24-hour report which is completed by the nursing supervisor on each shift and is reviewed daily by the DON/ADON will indicate if the care plan was evaluated or revised. The DON/ADON will review the care plan for accuracy. | | |

12/30/09 and
original

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 279 | <p>Continued From page 5</p> <p>§483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on clinical record review and interview, it was determined that the facility failed to develop a care plan for four (4) residents (R10, R41, R37 and R45) of the 18 sampled Stage 2 residents. Findings include:</p> <p>1. Review of the clinical record revealed that prior to 7/09, R45 was continent of bowel and bladder. The clinical record indicated that during 7/09, R45 developed periods of incontinence which continued to the current time. Although the facility implemented appropriate interventions to address the incontinence, they failed to develop a written plan of care for this problem.</p> <p>In an interview with E8 (MDS Coordinator) on 10/26/09, she acknowledged that a care plan for incontinence was never developed for R45.</p> <p>2. R10 was admitted to the facility on 6/30/09. On 7/16/09 an order was written for R10 to receive a dietary supplement due to variable meal intakes. On 8/7/09 the dietitian's notes stated that a dietary alert was received due to R10's weight loss.</p> <p>Although the facility implemented interventions to address R10's weight loss, they did not develop a written care plan until 10/12/09, approximately two (2) months after the problem was first identified.</p> <p>In an interview with E8 (MDS Coordinator) on</p> | F 279 | <p>F-279</p> <ol style="list-style-type: none"> 1. Care plans for all four residents have been updated 2. Nursing will be educated on the care plan process to review and revise care plans as indicated. 3. Nurses will review resident care plans when competing monthly summaries to determine if any changes or revisions are required. 4. The 24-hour report which is completed by the nursing supervisor on each shift and is reviewed daily by the DON/ADON will indicate if the care plan was evaluated or revised. 5. The DON/ADON will review the care plan for accuracy. <p>12/30/09 and ongoing</p> | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|--|----------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 279 | <p>Continued From page 6</p> <p>10/26/09, she acknowledged that R10's care plan for weight loss was not completed in a timely manner.</p> <p>3. Review of R41's clinical record revealed that on 10/9/09 a physician's order was written for "Hospice consult. Admit to hospice if appropriate." On 10/15/09 a "Hospice Assessment/Intervention/Plan" was completed which stated that R41 was admitted to hospice services.</p> <p>Review of the facility care plan for R41 lacked a care plan that included a coordination of facility and hospice services. The separate hospice care plan was not complete and did not list goals and approaches that were to be provided by hospice, but only included the amount of hours being provided by the hospice service.</p> <p>The facility care plan failed to include that R41 was a hospice resident and failed to identify the care and services that the facility would provide and which ones the hospice would provide.</p> <p>4. Review of R37's clinical record revealed a physician's order, dated 6/25/09 for Ativan 0.5 mg every 4 hours as needed for anxiety/restlessness. On 9/28/09 the order was increased to Ativan 1 mg every 4 hours as needed for agitation/anxiety.</p> <p>Review of the medication administration record (MAR) revealed that R37 received approximately 18 doses of the Ativan between 9/14/09 and 10/26/09. Despite the increased use of Ativan, the facility failed to develop a plan of care to address R37's agitation/behaviors.</p> <p>During an interview with E13 (nurse) on 10/26/09</p> | F 279 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 279 | Continued From page 7 | F 279 | | | |
| F 280 | at 12:29 PM, E13 acknowledged that a care plan addressing R37's agitation/behaviors was lacking. | F 280 | | | |
| SS=D | 483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS | | | | |
| | The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. | F-280 | 1. Resident 53 has an appropriate cushion which he finds to be satisfactory. Resident 51's care plan was updated on 8/25/09 with the appropriate PT recommendation from 8/21/09. | | |
| | A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. | | 2. All care plans will be reviewed and revised based on new interventions and will be documented as such when indicated. Nursing staff will be in-serviced on the care plan process. | | |
| | This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that 2 residents' (R51 and R53) out of 18 sampled stage 2 residents, care plans were evaluated and revised as needed. Findings include: | | 3. All incidents, new orders, and changes in clinical conditions will be documented on the 24-hour report and added to the care plan as appropriate. | | |
| | Cross-refer to F314 | | 4. The shift supervisor will review the 24-hour report and cross reference nurses notes and care plans to ensure the care plans have been reviewed and revised. | | |
| | 1. Review of R53's care plan entitled "actual impaired skin integrity: Ankle (Stage 3) and Sacrum (Stage 2)" dated 10/20/09 revealed the | | 5. The ADON/DON will monitor the care planning process to assure information is timely. | | |

11/30/09
and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 280 | <p>Continued From page 8</p> <p>following interventions: "Provide ROHO cushion(chair cushion that has individual interchangeable air cells that allow air to slowly and evenly distribute body weight pressure), Turn and reposition q 2-4 hrs. and assess skin for redness".</p> <p>In an interview with E7 (CNA) on 10/22/09, she stated that R53 was refusing to use the chair cushion and was physically removing it. E7 stated several different cushions were implemented, however, the resident would always ask staff to remove them. E7 stated she was unsure which cushion R53 was suppose to be using currently.</p> <p>According to R53's "Wound Evaluation Flow Sheet" dated 10/20/09 for the Stage 2 sacral pressure sore, the current preventative intervention was the "gel cushion".</p> <p>On 10/22/09 E4 (LPN) stated that since "Tuesday" 10/20/09 he (R53) had not used the chair cushion.</p> <p>According to the Wound Evaluation Flow Sheet dated 10/22/09 of R53's sacral pressure ulcer, the current preventative interventions were "Recliner 10/20, gel cushion in w/c, foam cut out in recliner 10/22/09".</p> <p>R53's care plan on "Actual Impaired skin Integrity" dated 10/20/09 was not revised and failed to reflect the interventions identified such as gel cushions in wheel chair, the foam cut out in the recliner and this resident's refusal to use the cushions.</p> <p>2. R51 was admitted to the facility on 8/3/09 with diagnoses that included dementia, osteoporosis</p> | F 280 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|--|----------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 280 | <p>Continued From page 9 and restless leg syndrome.</p> <p>Review of R51's clinical record and incident reports revealed that this resident experienced the following falls with resulting injuries:</p> <p>a. 8/8/09 - resident was ambulating to the bathroom with a CNA, ran into a wheelchair in the bathroom, tipped forward, hit head (r) parietal area, lowered to the floor by CNA. On 8/11/09, the attending physician's progress note identified R51's ambulatory dysfunction/falls and recommended PT screening.</p> <p>A PT screen and evaluation (submitted to the Division on 10/29/09) was done on 8/14/09 and recommended to "increase ambulation with RW (roller walker) 2 people, contact guard, verbal cueing". The facility failed to evaluate and revise R51's care plan when it was updated on 8/25/09 to address PT's recommended instruction for safety awareness, that is, the need of 2 people when ambulating with a roller walker to prevent falls and injuries.</p> <p>b. An incident report dated 9/8/09 - R51 was observed by E12 from the facility's "living room" "getting up, grabbed walker and fall on her right knee and elbow. Couldn't get to her on time to prevent fall. Resident removed clip alarm. It was on reclining chair". Resident's statement was "I want to go to bed @ 9:30". R51 sustained skin tears below right knee...red mark to right elbow...clip alarm, walker away from resident's reach." Time of incident was 2115 (9:15 PM). After this incident, the care plan was not revised to reflect R51's requested bed time preference. No other corrective care plan intervention was identified.</p> | F 280 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|--|----------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 280 | Continued From page 10 Subsequently, another incident report dated 10/16/09 at 2117 (9:17 PM) stated that R51, while in the living room, fell "onto knees...hit frontal area on head" and sustained "very small open pin sized cut on forehead..skin tear on right knee...right knee hurt". R51 stated "I want to go to bed". The facility failed to evaluate R51's falls that occurred at the same time of the night and failed to revise the care plan accordingly to reflect R51's request for bed time preferences. While the facility included the intervention of a rolling walker dated 10/15/09 the facility failed to individualize the interventions to include the physical therapy recommendations of 2 person contact guard on 8/14/09 and 1 person contact guard on 8/21/09. Additionally while the facility reviewed the falls sustained by R51 the facility failed to include new interventions and approaches such as reduction in medications in the care plan revisions. | F 280 | | | |
| F 314 SS=D | 483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: | F 314 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|--|----------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085028 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 314 | <p>Continued From page 11</p> <p>Based on observation, record review and interviews, it was determined that the facility failed to ensure one (1) resident (R53) out of 18 sampled stage 2 residents, received the necessary treatment and services to prevent new sores from developing. R53 was admitted to the facility with a Stage 3 right ankle pressure sore. Twenty two days after admission to the facility, R53 developed a Stage 2 pressure ulcer on the sacrum. Findings include:</p> <p>R53 was admitted to the facility on 10/8/09 from the Hospital with diagnoses that included S/P Fracture (FX) Right (R) Rib, Fractured Right Clavicle, Stage 3 right outer ankle pressure ulcer and peripheral neuropathy. According to R53's facility "Admission Assessment" dated 10/8/09, his buttocks were "reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/16/09 stated that this resident's cognitive skills for daily decision-making were "modified independence - some difficulty in new situations only". R53 needed extensive physical assistance of one person for bed mobility and all other activities of daily living (ADLs).</p> <p>R53's Braden Scale assessment for Predicting Pressure Sore dated 10/9/09 indicated that this resident was assessed to have a potential problem/risk factor for friction and sheer (scored 2), due to, "... skin probably slides some extent against sheets, occasionally slides down in chair or bed", and "spends majority of each shift in bed or chair".</p> <p>The facility initiated a care plan for R53 dated 10/09/09 on "Actual alteration in Skin Integrity" but did not document or identify the areas of actual</p> | F 314 | <p>F-314</p> <ol style="list-style-type: none"> 1. The resident's wound was healed stage II as of 10/23/09 2. All residents have appropriate treatment and services to prevent pressure ulcers. Weekly skin assessments are conducted with nurse/C.N.A. Findings are documented and interventions implemented as appropriate. 3. Pressure ulcer care plans will be updated to reflect actual alteration in skin integrity for all residents with pressure wounds. The documentation will include the location and stage of the wound on the care plan. 4. The ADON/designee will review the care plan and wound care documentation weekly to ensure the care plan has been reviewed and revised for appropriate interventions and documentation of alteration in skin integrity is noted on the care plan. | 11/30/09 and ongoing | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|--|--|---|--|--|---|
| STATEMENTS OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 314 | <p>Continued From page 12</p> <p>skin alteration. The interventions included "Provide pressure redistributing mattress", "provide cushion to chair", "turn and reposition q 2- 4 hours" and "assess skin for redness", Off load heels while in bed" Skin assessments per policy" and "Provide treatments as ordered."</p> <p>In an interview with E7 (day shift Certified Nursing Assistant) on 10/22/09 at 2:35 PM, she stated that the CNAs on the 3-11 PM shift were responsible for performing skin checks on the resident's bath days. R53's bath days were on Mondays and Thursdays. Review of the CNA Flow Records for 10/09 revealed documentation that R53 received a daily partial bath and had the showers on Mondays and Thursdays (10/9, 10/12, 10/15, 10/19/2009) on the 3-11 PM shifts. There was no documentation noting changes occurred on R53's buttocks between 10/9/09 through 10/18/09. On 10/22/09, according to E7, R53 complained that his "bottom" was hurting and she discovered that the buttock (sacrum) "broke". E7 could not remember the date, but she stated that she reported to the nurse that R53's skin on the "buttock broke".</p> <p>Review of R53's "Wound Evaluation Flow Sheet" dated 10/20/09 revealed that R53 developed a Stage 2 pressure ulcer on his left buttock that measured "L 2 W 0.8" as "red with macerated flap of skin covering open area". The current treatment was "Desitin" (previously prescribed on 10/11/09) and the current preventative intervention was "gel cushion".</p> <p>The facility updated the care plan on 10/20/09 and identified the "actual impaired skin integrity: Ankle (Stage 3) and Sacrum (Stage2). The interventions included Provide ROHO</p> | F 314 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|--|----------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19607 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 314 | <p>Continued From page 13</p> <p>cushion(chair cushion that has individual interchangeable air cells that allow air to slowly and evenly distribute body weight pressure), Turn and reposition q 2-4 hrs. and assess skin for redness.</p> <p>In an interview with E7 on 10/22/09, she stated that previously, R53 had several cushions on his recliner and or wheel chair before. He stated that he was uncomfortable with the "first cushion". E7 stated that after several cushions were attempted, he would ask the staff to take it off. He always sat inside his room. She was not sure what cushion was to be used currently.</p> <p>Even though the facility identified the use of a ROHO cushion, the turning and positioning q 2-4 hours and assess skin for redness in the care plan, they failed to have a system in place to assure that interventions were consistently implemented, monitored and or devices were used/modified as appropriate</p> <p>On 10/21/09 R53 was observed seated in his recliner without any seat cushion.</p> <p>During an interview with R53 on 10/22/09 at approximately 7:45 AM, R53 was observed seated in his recliner and the foam cushion was observed on the floor. R53 acknowledged that he did not have the chair cushion on the recliner. He stated that he used to sit in a different type of chair "about 4-5 days ago" and requested to have the chair replaced to his present recliner. He stated that the old chair was small and uncomfortable.</p> <p>The sacral pressure ulcer was re-evaluated by E3 (Wound Care Nurse) on 10/22/09 and measured</p> | F 314 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0381

| | | | | | |
|---|---|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 314 | Continued From page 14 "L 3.5 cm, W 1 cm , macerated left side". Although the measurement of the pressure ulcer had increased, E3 documented it as "improving". The documented current preventative interventions on the Wound Care sheet were "Recliner 10/20, gel cushion in w/c, foam cut out in recliner 10/22/09". These interventions were not addressed in the current care plan. | F 314 | | | |
| F 315 SS=D | 483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Cross-refer to F314 Based on record review, interview and review of facility policy and procedures, it was determined that the facility failed to ensure that one (1) resident (R53) out of 18 sampled stage 2 residents, who was incontinent of bladder received appropriate treatment and services to restore or improve normal bladder function to the extent possible. The facility failed to re-assess R53's continence status when he had a severe decline in bladder continence starting 3 days post admission) and failed to have a system in place to ensure that appropriate interventions were developed, implemented and monitored. Findings include: | F 315 F-315 | <ol style="list-style-type: none"> 1. Resident 53 is now continent of bowel and bladder. 2. All residents are evaluated on admission quarterly and with significant change. In-service education will be conducted related to the assessment of incontinence and to identify changes in incontinence of residents. Toileting schedules will be implemented if appropriate. 3. Nurses will be responsible to complete a 3-5 day voiding diary to establish a toileting plan and to update the bowel and bladder assessment when a change is noted. 4. The toileting plan will be a part of the C.N.A. flow sheet and be reviewed monthly by the DON/designee to determine any changes in continence status. | | |

12/31/09
and ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F-315 | <p>Continued From page 15</p> <p>The facility's policy entitled "Urinary Continence and Incontinence - Assessment and Management" was reviewed.</p> <p>R53 was admitted to the facility on 10/8/09 with diagnoses that included S/P Fracture (FX) Right (R) Rib, Fractured Right Clavicle and Left Macular degeneration. According to R53's Nursing "Admission Assessment" dated 10/8/09, this resident was "continent-complete control" of bladder and had no bladder problems. R53 was not receiving any diuretic medications. A 3 day "Voiding Diary" (every hour toileting) dated 10/8/09 through 10/10/09 was completed and indicated that R53 was continent of bladder.</p> <p>Review of R53's clinical record revealed documentation in the nurse's note that starting 10/11/09 through 10/18/09 this resident was discovered "grossly incontinent urine" and/or frequently incontinent of "large amount of urine". R53 "felt embarrassed about incontinent episode".</p> <p>A nurse's note dated 10/19/09 and timed 7:05 AM stated, "able to get his pants and attends down as well as placed urinal without difficulty...need assistance with pulling pants back up".</p> <p>In an interview with R53 on 10/22/09 he stated that he had worn pads/depends since he was admitted here from the hospital. He stated that he had more important things to worry about than to worry about "wetting". According to E7 (CNA) on 10/22/09, she stated that R53 "was depressed and did a lot of crying" due to his wife's recent death.</p> | F 315 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 315 | <p>Continued From page 16</p> <p>According to R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/16/09, and admission MDS assessment dated 10/20/09 indicated that this resident was "frequently incontinent of bladder (coded 3). Additionally, according to these assessments, R53's cognitive skills for daily decision-making were "modified Independence-some difficulty in new situations only" and did not have a short and long term memory problem. He needed extensive assistance with transfer, toileting and all other activities of daily living due to his impaired mobility related to his fractured right rib and clavicle and use of a sling to his right arm.</p> <p>The facility initiated a care plan on "Self-care deficit R/T Fx of ribs and clavicle: Assistance Required" and dated 10/20/09. The interventions included "Toileting Assist: One person extensive assist...Handrail in BR (bathroom) for toileting and Provide urinal".</p> <p>Review of R53's clinical record revealed that the facility lacked documentation that the causes of the resident's incontinence were assessed nor that the facility initiated a care plan prior to 10/16/09 and 10/20/09 to address appropriate interventions such as a scheduled toileting, prompted voiding, a toileting trial, or other interventions to try to manage and monitor R53's incontinence.</p> <p>During an interview with E6 (MDS Coordinator) on 10/22/09 at approximately 3:45 PM, she acknowledged that there was no toileting schedule in place and that R53 needed another "voiding diary" (toileting trial) and an individualized care plan for his incontinence.</p> | F 315 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 315 | Continued From page 17 | F 315 | | | |
| F 444 SS=D | <p>Subsequently, the facility completed a voiding diary on 10/22/09 through 10/24/09, the results of which indicated that R53 did not have Incontinent episodes since he was toileted every hour.</p> <p>483.65(b)(3) PREVENTING SPREAD OF INFECTION</p> <p>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy and procedure and interview, it was determined that the facility failed to ensure that proper handwashing was observed during a wound dressing change for 1 (one) resident (R53) out of 18 sampled stage 2 residents. Findings include:</p> <p>The facility's Policy entitled "Handwashing/Hand Hygiene" was reviewed.</p> <p>E4 (LPN) was observed performing wound care on R53's Stage 3 Right ankle wound on 10/22/09 @10:30 AM. The following were observed during the wound dressing treatment: A clean field was set up on top of the resident's bedside table. There was no accessible plastic bag set up to contain the soiled dressing.</p> <p>R53 was lying comfortably in bed with his right leg on top of a clean towel. E4 was not observed to wash her hands prior to donning a pair of clean gloves. She then proceeded to remove the soiled dressings on R53's right ankle wound. A trash can lined with plastic bag was located against the</p> | F 444 | <p>F-444</p> <ol style="list-style-type: none"> 1. The wound care and hand washing policy was reviewed with the nurse on 10/22/09. 2. All nursing staff will be educated on the proper procedure for hand washing and wound care procedure. 3. A wound care competency will be conducted for all licensed staff which will include return demonstration of the wound care procedure. 4. A random audit will be conducted on the wound care procedure on a quarterly basis and reported on through the quality improvement committee. 5. The ADON/designee will be responsible for the oversight and monitoring of wound care. | | |

12/31/09
and
ongoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 444 | <p>Continued From page 18</p> <p>wall inside the room but was not within E4's reach. E4 proceeded to remove her contaminated gloves after handling the soiled dressing, donned a new pair of clean gloves without handwashing or using an alcohol based handrub. E4 cleansed the ankle wound with normal saline solution. She proceeded to apply the hydrogel ointment with a cotton tip applicator. E4 removed only her soiled right hand glove and kept her soiled left hand glove instead of removing both. She donned a clean glove on her right hand without first handwashing and used the left hand with the contaminated glove to place the glove on the right hand. E4 cleansed the area around the wound with a prepared skin prep gauze, then applied the Tegaderm cover to the wound. E4 removed both gloves and then went to the bathroom and donned a new pair of gloves without handwashing. Additionally, during the entire wound treatment procedure, all soiled supplies used to treat and cleanse the wound were piled on one side of the towel that was placed under R53's right leg and adjacent to his right leg instead of placing them in a plastic bag away from the resident. E4 finished the treatment and collected all soiled dressing/treatment supplies piled up on the towel next to R53's right leg with her gloved hands and threw them in the trash can located against the wall of the room. E4 did not wash hands and/or use an alcohol based hand rub after she removed her contaminated gloves. E4 proceeded to help R53 to put his shoes back on.</p> <p>The wound treatment nurse failed to wash hands before donning clean gloves to perform a wound dressing change after handling soiled dressings and removing gloves and before handling the clean dressings, and after removing and</p> | F 444 | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|--|---|---|----------------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | |
| F 444 | Continued From page 19 disposing of soiled dressing supplies in accordance with infection control practices and current standards of practice. | F 444 | | | |
| F 514 SS=D | <p>This finding was discussed and acknowledged by E2 (Director of Nursing) on 10/22/09.</p> <p>483.75(l)(1) CLINICAL RECORDS</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that the clinical record for one (1) resident (R10) out of 18 sampled Stage 2 residents was maintained in accordance with accepted professional standards of practice that were complete and accurately documented. Findings include:</p> <p>R10 had a physician's order, dated 8/3/09 for Glucerna 1 can twice a day. Review of the 8/09 medication administration record (MAR) revealed multiple blanks with no signatures to indicate that the Glucerna was not given.</p> <p>During an interview with E5 (nurse) on 10/23/09</p> | F 514 | | | |
| | | F-514 | <ol style="list-style-type: none"> 1. The resident's weight is stable. The resident receives glucerna or ensure pudding based on her preference. 2. Nursing staff will be in-serviced on the acceptable professional standard of documentation. 3. Medical administration records and treatment administration records will be reviewed weekly by the shift supervisor to determine appropriate documentation. 4. Any missing documentation will be reviewed with the appropriate nurse. 5. The ADON/DON will monitor compliance with documentation standards. | 12/31/09 and ongoing | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 12/04/2009
FORM APPROVED
OMB NO. 0938-0391

| | | | | | |
|---|---|---|--|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 085026 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 514 | Continued From page 20 at 2:00 PM, E5 acknowledged that the 8/09 MAR had many blanks for the Glucerna and that even though the resident was refusing it many times it still needed to be documented on the MAR. | F 514 | | | |

| | | | | |
|--|--|--|---|---|
| STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs | | PROVIDER # 085026 | MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | DATE SURVEY COMPLETE: 10/27/2009 |
| NAME OF PROVIDER OR SUPPLIER STONEGATES | | STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE | | |
| ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES | | | |
| F 466 | <p>483.70(h)(1) PROCEDURES TO ENSURE WATER AVAILABILITY</p> <p>The facility must establish procedures to ensure that water is available to essential areas when there is a loss of normal water supply.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the emergency procedures on 10/23/09, the emergency water procedure was found not to address the source of non-potable water.</p> <p>Review of the emergency water procedure found in the facility emergency manual revealed that potable water was covered as part of an emergency water loss. The non-potable water was not covered in the procedure. Review of this procedure with E14 (maintenance staff) on 10/23/09 at 9:20 AM revealed that the facility did not have a procedure that covered nonpotable water although they have vendors that can provide a tanker if necessary.</p> <p>Review of the procedures with E1 (Administrator) on 10/23/09 revealed the facility gets their water supply from the city and they would use whatever they had in place although they did not have this procedure at the facility. On 10/26/09 at 11:15am, a copy of a document entitled "Prepare a Family Emergency Kit" (online source: City of Wilmington Disaster Plan) was given to the surveyor which contained a paragraph on water. It stated to save one gallon of water per person per day and keep at least a 3 day supply of water per person (2 qts for drinking and 2 quarts for each person in your household for food/sanitation).</p> | | | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above isolated deficiencies pose no actual harm to the residents



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLICRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

LTC Residents Protection

NOV 25 2009

Director's Office

STATE SURVEY REPORT

Page 1 of 4

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: October 27, 2009

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
|---------|--|---|
|---------|--|---|

The State Report incorporates by reference and also cites the findings specified in the Federal Report.

An unannounced QIS annual survey was conducted at this facility from October 19, 2009 through October 27, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 41. The survey sample included forty (40) census sample residents and twelve (12) admission sample residents in Stage 1. The Stage 2 sample totaled eighteen (18) residents.

3201 Skilled and Intermediate Care Nursing Facilities

3201.6.0 Services To Residents

3201.6.1 General Services

3201.6.1.1
The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.

Provider's Signature Kim M. Carr

Title Administrator

Date 11/23/09



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 2 of 4

DATE SURVEY COMPLETED: October 27, 2009

NAME OF FACILITY: Stonegates

| ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED | |
|---|--|
| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies |
| 3201.6.5 3201.6.5.7 | <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 10/27/09, F157, F314, F315, and F444.</p> <p>Nursing Administration</p> <p>The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 10/27/09, F279 and F280.</p> <p>Records and Reports</p> <p>There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the</p> |
| 3201.6.10 3201.6.10.1 | <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L, survey date completed 10/27/09, F279 and F280.</p> <p>Records and Reports</p> <p>There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the</p> |

F-157

1. The physician was notified of the resident's continence status at the time of the survey.
2. Notification of the appropriate party will be documented in the medical record for accidents, injuries, and for significant changes in condition or treatment.
3. Licensed staff will be in-serviced on the regulatory requirement related to notification.
4. All documented notification will be indicated on the 24-hour report which is reviewed daily by the DON/ADON.

Completion date 12/30/09



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DESSA
3 Mill Road
Wilmington, Delaware 19806
(302) 577-3867

STATE SURVEY REPORT

Page 2 of 4

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: October 27, 2008

SECTION

**STATEMENT OF DEFICIENCIES
Specific Deficiencies**

**ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH
ANTICIPATED DATES TO BE CORRECTED**

This requirement is not met as evidenced by:

Cross-refer to CMS 2567a, survey data completed 10/27/09, #157, F314, F315, and F404.

3201.6.5

Nursing Administration

3201.6.5.7

The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.

This requirement is not met as evidenced by:

Cross-refer to CMS 2567a, survey data completed 10/27/09, F279 and F280.

1201.6.10

Records and Reports

1201.6.10.1

There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the

F-315

1. Resident 53 is now continent of bowel and bladder.
2. All residents are evaluated on admission quarterly and with significant change. In-service education will be conducted related to the assessment of incontinence and to identify changes in incontinence of residents. Toileting schedules will be implemented if appropriate.
3. Nurses will be responsible to complete a 3-5 day voiding diary to establish a toileting plan and to update the bowel and bladder assessment when a change is noted.
4. The toileting plan will be a part of the C.N.A. flow sheet and be reviewed monthly by the DON/designee to determine any changes in continence status.

Completion: 12/31/09 and ongoing



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6861

STATE SURVEY REPORT

Page 2 of 4

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: October 27, 2009

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
|---------|--|---|
|---------|--|---|

This requirement is not met as evidenced by:

Cross-refer to CMS 2567-L, survey date completed 10/27/09, F157, F314, F315, and F444.

Nursing Administration

The assessment and care plan for each resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date of the last full assessment.

This requirement is not met as evidenced by:

Cross-refer to CMS 2567-L, survey date completed 10/27/09, F279 and F280.

Records and Reports

There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the

F-444

1. The wound care and hand washing policy was reviewed with the nurse on 10/22/09.
2. All nursing staff will be educated on the proper procedure for hand washing and wound care procedure.
3. A wound care competency will be conducted for all licensed staff which will include return demonstration of the wound care procedure.
4. A random audit will be conducted on the wound care procedure on a quarterly basis and reported on through the quality improvement committee.
5. The ADON/designee will be responsible for the oversight and monitoring of wound care.

Completion: 12/31/09 and ongoing



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 3 of 4

NAME OF FACILITY: Stonehedges

DATE SURVEY COMPLETED: October 27, 2009

| ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED | |
|---|--|
| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies |
| 3201.6.10.1.7 | <p>Medication administration record (MAR) including medications, dosages, frequency, route of administration, and initials of the nurse administering each dose. The record shall include the signature of each nurse whose initials appear on the MAR.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross refer to CMS 2567-L, survey date completed 10/27/09, F514</p> <p>Patient's rights</p> <p>It is the intent of the General Assembly, and the purpose of this section, to promote the interest and well-being of the patients and residents in sanatoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interest of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following:</p> <p>(1) Every patient and resident shall have the</p> |
| 16 Del. C., Chapter 11, Subchapter II, § 1121 | <p>F-314</p> <ol style="list-style-type: none">1. The resident's wound was healed stage II as of 10/23/092. All residents have appropriate treatment and services to prevent pressure ulcers. Weekly skin assessments are conducted with nurse/C.N.A. Findings are documented and interventions implemented as appropriate.3. Pressure ulcer care plans will be updated to reflect actual alteration in skin integrity for all residents with pressure wounds. The documentation will include the location and stage of the wound on the care plan.4. The ADON/designee will review the care plan and wound care documentation weekly to ensure the care plan has been reviewed and revised for appropriate interventions and documentation of alteration in skin integrity is noted on the care plan. <p>Completion: 11/30/09 and ongoing</p> |



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-8661

STATE SURVEY REPORT

Page 3 of 4

DATE SURVEY COMPLETED: October 27, 2009

NAME OF FACILITY: Stonegates

**STATEMENT OF DEFICIENCIES
Specific Deficiencies**

**ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH
ANTICIPATED DATES TO BE CORRECTED**

SECTION

following:

3201.6.10.1.7

Medication administration record (MAR) including medications, dosages, frequency, route of administration, and initials of the nurse administering each dose. The record shall include the signature of each nurse whose initials appear on the MAR.

This requirement is not met as evidenced by:

Cross refer to CMS 2567-L, survey date completed 10/27/09, F514

Patient's rights

**16 Del. C.,
Chapter 11,
Subchapter II,
§ 1121**

It is the intent of the General Assembly, and the purpose of this section, to promote the interest and well-being of the patients and residents in sanatoria, rest homes, nursing homes, boarding homes and related institutions. It is declared to be the public policy of this State that the interest of the patient shall be protected by a declaration of a patient's rights, and by requiring that all facilities treat their patients in accordance with such rights, which shall include but not be limited to the following:

(1) Every patient and resident shall have the

F-514

1. The resident's weight is stable. The resident receives glucerna or ensure pudding based on her preference.
2. Nursing staff will be in-serviced on the acceptable professional standard of documentation.
3. Medical administration records and treatment administration records will be reviewed weekly by the shift supervisor to determine appropriate documentation.
4. Any missing documentation will be reviewed with the appropriate nurse.
5. The ADON/DON will monitor compliance with documentation standards.

Completion: 12/31/09 and ongoing



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 4 of 4

NAME OF FACILITY: Stonegates

DATE SURVEY COMPLETED: October 27, 2009

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
|---------|--|--|
| | <p>right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 10/27/09, F241.</p> | <p>F-279</p> <ol style="list-style-type: none">1. Care plans for all four residents have been updated2. Nursing will be educated on the care plan process to review and revise care plans as indicated.3. Nurses will review resident care plans when competing monthly summaries to determine if any changes or revisions are required.4. The 24-hour report which is completed by the nursing supervisor on each shift and is reviewed daily by the DON/ADON will indicate if the care plan was evaluated or revised.5. The DON/ADON will review the care plan for accuracy. <p>Completion: 12/30/09 and ongoing</p> |



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6661

STATE SURVEY REPORT

Page 4 of 4

NAME OF FACILITY: Stonewates

DATE SURVEY COMPLETED: October 27, 2009

| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies | ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED |
|---------|--|---|
| | <p>right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 10/27/09, F241.</p> | <p>F-280</p> <ol style="list-style-type: none">1. Resident 53 has an appropriate cushion which he finds to be satisfactory. Resident 51's care plan was updated on 8/25/09 with the appropriate PT recommendation from 8/21/09.2. All care plans will be reviewed and revised based on new interventions and will be documented as such when indicated. Nursing staff will be in-serviced on the care plan process.3. All incidents, new orders, and changes in clinical conditions will be documented on the 24-hour report and added to the care plan as appropriate.4. The shift supervisor will review the 24-hour report and cross reference nurses notes and care plans to ensure the care plans have been reviewed and revised.5. The ADON/DON will monitor the care planning process to assure information is timely. <p>Completion: 11/30/09 and ongoing</p> |



**DELAWARE HEALTH
AND SOCIAL SERVICES**

Division of Long Term Care
Residents Protection

DHSS - DLTCRP
3 Mill Road, Suite 308
Wilmington, Delaware 19806
(302) 577-6681

STATE SURVEY REPORT

Page 4 of 4

DATE SURVEY COMPLETED: October 27, 2009

NAME OF FACILITY: Stonesates

| ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED | |
|---|---|
| SECTION | STATEMENT OF DEFICIENCIES Specific Deficiencies |
| | <p>right to receive considerate, respectful, and appropriate care, treatment and services, in compliance with relevant federal and state law and regulations, recognizing each person's basic personal and property rights which include dignity and individuality.</p> <p>This requirement is not met as evidenced by:</p> <p>Cross-refer to CMS 2567-L survey date completed 10/27/09, F241.</p> |
| F-241 | <p>All health care staff will be in-serviced regarding the positive dining experience. General rules regarding interaction between resident and staff will be posted in both pantry areas in addition to the in-service. Nursing supervisor will monitor the dining experience of our residents to ensure the dining experience is one that promotes dignity and quality of life of our residents. A nurse will be designated to oversee the dining room during the meal service. This monitoring will be on going for all meals.</p> <p>Completion: 12/31/09 and ongoing</p> |